Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Physicians and Professional Practitioners, Laboratory, Durable Medical Equipment and Supplies, and Ambulatory Surgical Centers Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: May 1, 2013

SUBJECT: Implementation of the Medicaid National Correct Coding Initiative (NCCI), Procedure to Procedure (PTP), and Medically Unlikely Edits (MUE) — ***Effective June 3, 2013***

This purpose of this memorandum is to inform providers that, effective June 3, 2013, the Department of Medical Assistance Services (DMAS) will be implementing the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (Medicaid NCCI), Procedure to Procedure (PTP), and Medically Unlikely Edits (MUE) developed for Medicaid. All Health Care Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) codes will be subject to both the Medicaid NCCI and ClaimCheck edits. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. These edits will be based on claims received on or after June 3, 2013, regardless of the date(s) of service.

This implementation is in response to directives in the Affordable Care Act of 2010, in which CMS requires all state Medicaid agencies to implement the Medicaid NCCI methodology. The Medicaid NCCI edits are based on coding conventions defined in the American Medical Association's CPT manual, coding guidelines developed by national societies, analysis of standard medical and surgical practice and current coding practices per CMS.

Medicaid NCCI edits are invoked based on the following global claim factors: same recipient, same servicing provider, same date of service.

Medicaid NCCI edits will be implemented into the daily claims adjudication cycle on a concurrent basis, no different than how NCCI and ClaimCheck edits work today. This implementation will result in current claims being processed to edit against historical claims data and reported via the weekly remittance advice.

CMS updates the Medicaid NCCI PTP/MUE edits on a quarterly basis. DMAS will make every attempt to implement the newest updates as soon as they become available. DMAS will not be sending out quarterly notifications to providers reminding them of the quarterly update but will post the current version being used on the DMAS website. This can be accessed by, going to www.dmas.virginia.gov, click on Provider Services, Claims and Billing Information.

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS had modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. Effective June 3rd, this will no longer be occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

DMAS will be implementing the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE , potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim. Upon review of the MUE denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

For more detailed information related to the specific Medicaid PTP and MUE edits, please visit CMS's website at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

Special Exemptions

All CPT/HCPCS codes will be subject to the Medicaid NCCI edits. The only exemptions are those DMAS specific CPT/HCPCS codes which require a valid service authorization. These codes will be exempt from the MUE edits only. They are still subject to the PTP and Claim Check edits. For a listing of the specific codes which require service authorization, please refer to the DMAS website @ www.dmas.virginia.gov, "What's New", Procedure Fee Schedule Files and access the applicable HCPCS or CPT code files. The SA indicator is located under the field, PA_TYPE. A key to the PA type can be found by clicking on the Frequently Asked Section bullet on the page titled Procedure Fee Files & CPT Codes.

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC), Rural Health Clinics (RHC), Schools and Health Departments.

CPT/HCPCS Procedure Codes in ClaimCheck

DMAS will continue to utilize the McKesson ClaimCheck software edits. These edits will occur after the Medicaid NCCI edits. ClaimCheck edits are based on guidelines specified in the Current Procedural Terminology (CPT) Manual as well as guidelines from the American Medical Association (AMA), the Centers for Medicare and Medicaid (CMS) and specialty society/association recommendations/guidelines. The ClaimCheck edits primarily focus on unbundling services, billing for procedures considered to be incidental or mutually exclusive to another procedure, and billing for a pre-operative or post-operative visit that is considered part of the global surgical package.

Appropriate Use of Modifiers

Currently, DMAS allows claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. **Effective June 1, 2013, this will no longer be in effect**. DMAS can only allow the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or their agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 – E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91.

Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Preventive Care and Immunizations

The new PTP edits in the Medicaid NCCI do pair the immunization administration codes (CPT codes 90460-90474) and the Preventive Medicine Service Evaluation and Management (E&M) codes (99381-99429). The Preventive Medicine E&M services are only covered by DMAS for those members age 21 and younger. Note that the immunization codes assigned by CMS are not covered by DMAS. The current DMAS reimbursement policy for vaccines has not changed.

New DMAS Edits

DMAS has created new edit reason codes to correlate with the PTP and MUE edits, The new reason codes for the Medicaid NCCI PTP edit will be 0792 (ClaimCheck NCCI PTP edit) and 0793 (ClaimCheck NCCI PTP edit). The new reason code for the Medicaid NCCI MUE edit will be 0794 (ClaimCheck NCCI MUE). History edits will still occur with the PTP edits. An example of this would be: a claim is submitted with a column two CPT/HCPCS code and is paid; the second claim with the column one code is submitted, when the second claim is processed, the system will void the payment for the first claim using the void reason 1195. The provider remittance will show the void reason as well as the EOB 0792/0793 to indicate it is a Medicaid NCCI PTP edit. The new edits for EAPG are 0320 (EAPG NCCI PTP edits) and 0323 (EAPG NCCI MUE edits).

Durable Medical Equipment and Supply (DMES) Providers

DME providers will be subject to the PTP and MUE edits established by CMS for CPT/HCPCS codes. When billing for a DME product which spans more than one day, the provider must note the date range on the claim and the appropriate number of units (Example: CPT/HCPCS code E1234 rental for 31 days in January, providers will need to bill as: 1/1/2013-1/31/2013 for 31 units, and not 1/1/2013 -1/1/2013 for 31 units). Providers submitting claims with the same begin and end date and the units greater than one, are subject to the MUE denials.

Reconsiderations

Providers may request reconsideration of actions taken by a Medicaid NCCI PTP/MUE edit or ClaimCheck edit via email (ClaimCheck@dmas.virginia.gov) or by submitting a written request to the mailing address:

Department of Medical Assistance Services
Payment Processing Unit
ATTN: ClaimCheck/Medicaid NCCI
600 East Broad Street Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting a reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

In the event a provider disagrees with the denial of a claim based on Medicaid NCCI regulations DMAS does not have the authority to override the PTP, the modifier indicator or MUE edits. Providers who receive denied claims as result of incorrect billing, may resubmit the corrected claim. Incorrect billing can be the failure to submit the correct CPT/HCPCS code, incorrect modifier or wrong dates of service (range).

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering Internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com (888) 661-5657	Siemens Healthcare (HDX Division) www.hdx.com (610) 219-1600	Emdeon www.emdeon.com (877) 363-3666	Availity, LLC www.availity.com support@availity.com (800) 282-4548	Dorado Systems, LLC www.Doradosystems.com sales@doradosystems.com (856) 354-0048

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.